Output Driven Resource Allocation - A Simple Explication

Valuing Business Plans – The Basic Equation

Capitated Payment based on Enrollment at MTF

−

Fee for Service Payment for MTF-enrollee care delivered by MCSC

−

Fee for Service Payment for MTF-enrollee care delivered by other MTFs

+

Fee for Service Payment for non-MTF-enrollee care delivered at the MTF

=

Production Plan Value

Valuing Business Plans – The Basic Equation

Capitated Payment based on Enrollment at MTF ($1,150 * Enrollees)

–

Fee for Service Payment for MTF-enrollee care delivered by MCSC (RVU*$74 +RWP*$5,628)

–

Fee for Service Payment for MTF-enrollee care delivered by other MTFs (RVU*$74 +RWP*$5,628)

+

Fee for Service Payment for non-MTF-enrollee care delivered at the MTF (RVU*$74 +RWP*$5,628)

=

Production Plan Value

How do you win?

Valuing Business Plans – A simple example -

Capitated Payment based on Enrollment at MTF ($1,150 * 10,000) = 11,500,000

–

Fee for Service Payment for MTF-enrollee care delivered by MCSC $6,000,000

–

Fee for Service Payment for MTF-enrollee care delivered by other MTFs 2,800,000

+

Fee for Service Payment for non-MTF-enrollee care delivered at the MTF (17,000*$74) = 740,000

=

Production Plan Value = $3,440,000

How does this Compare with the Current Budget?

- O&M and MILPERS = ~$13 Million
- ODRA for Clinical Care = $3.5 Million
- Does Lab, Radiology, Pharmacy and Readiness at an Ambulatory MTF really cost ~$9.5 million?

Future Budget Components

Current year Actual Opsut Production Value + TFL Value of Care

+

- Lab
- Radiology
- Pharmacy
- GME
- Readiness
- Outpatient Institutional Expenses
- Occ Health
- IH
- Etc?

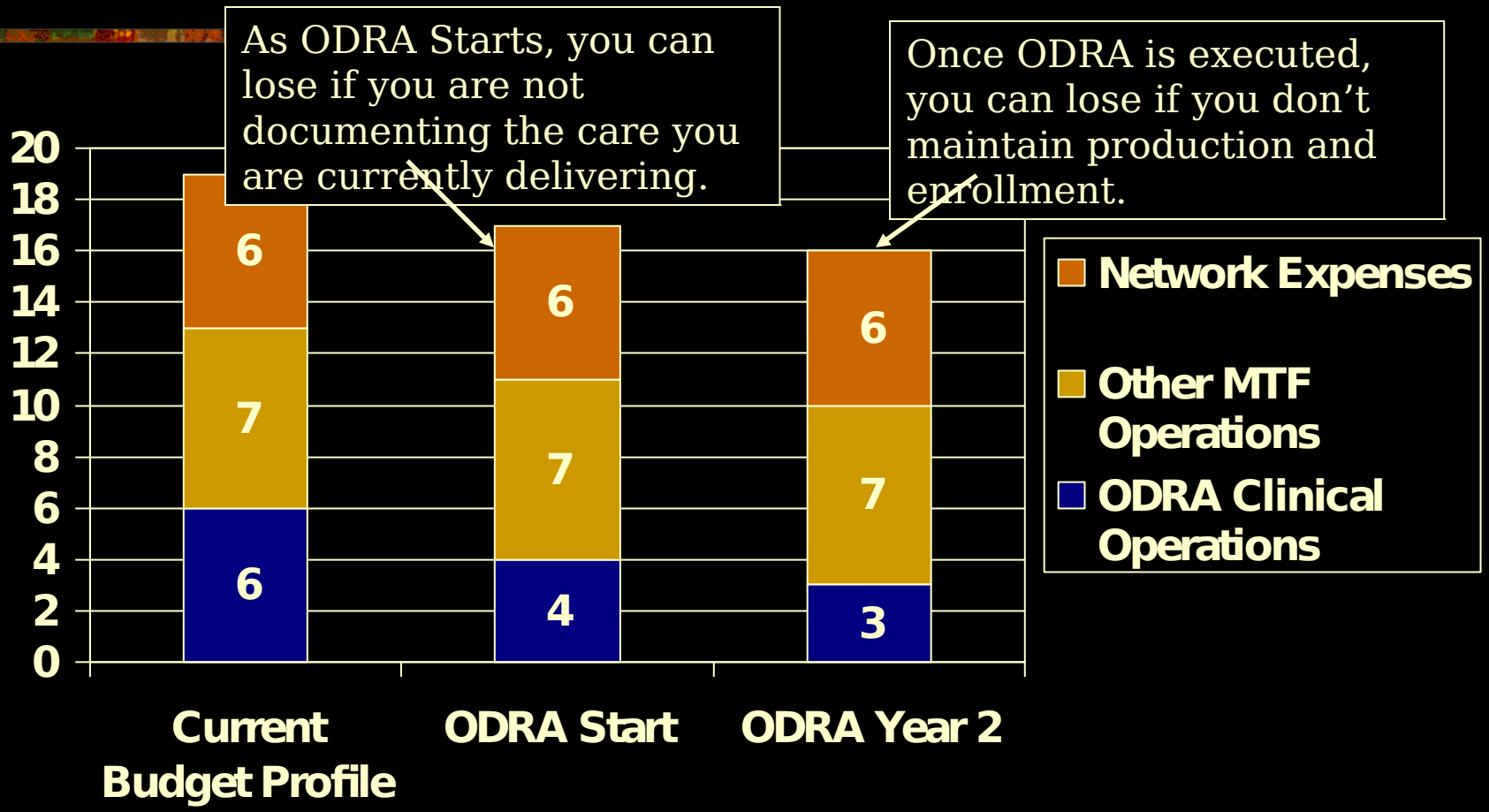
+

Network Expenses

=

Total Budget

Risk Under ODRA Budgeting



Documented Production Matters !

How Do you Survive Under ODRA

- Increase Production of RVUs and RWPs = Increase Value of Care or “Revenue”
- Reduce Network Expenses
- Reduce Operating Expenses

RVUs and CMAC Rates

RVUs

- RVUs – Non-monetary, relative units of measure of health care services and relative differences in resources consumed when providing different services and procedures.
- They were developed to provide a more acceptable and perhaps, more competitive payment system for physicians across all specialties.
- RVUs were not designed to be risk adjusters, case severity adjusters, or determinants of coding compliance.
- At the beginning CPT 99213 was designated as 1.0 RVU (that has since changed)

RVU Components

- Work = Physician and/or non-physician provider's compensation including benefits.
- Practice = Overhead; staff salaries, supplies, equipment, building expenses, utilities and taxes.
- Malpractice = Medicolegal risk involved with the provision of each service.

RVU Examples

CPT-4	Brief Description	RVUw	RVUpe	RVUm	RVUt
99212	Office Visit / Established Patient	0.45	0.59	0.02	1.06
44370	Endoscopy	4.80	1.74	0.21	6.75
59400	Obstetrical Care	23.06	15.41	4.14	42.61

Payment Methodology

- Medicare converts RVU value to monetary value through geographic adjustment and then a multiplier.
- The multiplier for 2002 was $36.19
- But, Medicare uses the total RVU not just work.
- In 2002, for all RVUs:
  - Work Component 52%
  - Practice Expense 43%
  - Malpractice 5.5%

CMAC

- CHAMPUS Maximal Allowable Charge
- Set each year for every service that is a covered benefit under TRICARE
- Adjusted for regional variation
- Basis for payment of claims.
- Not necessarily related to the resources required to produce the service, but should be.

Why Look at Both RVUs and CMAC Rates?

- Work RVUs can be used to evaluate provider productivity. Benchmarks exist for each specialty.
- CMAC rates are a reasonable means for calculating the cost of providing care in the network when evaluating make vs buy.